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Louisiana Asks Congress to Stop Healthcare Discrimination for Five Million Dually Eligible People with Medicare and Medicaid

The Louisiana Resolution to Restore Equal Access to Medicare
Will Improve Healthcare Finances and Decrease Healthcare Disparities

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The Louisiana Resolution to Restore Equal Access to Medicare

In June 2009, the Louisiana State Legislature *unanimously* passed House Concurrent Resolution 173, a Resolution to Restore Equal Access to Medicare. This Resolution states:

- The Legislature of Louisiana requests that the U.S. Congress restore Medicare-Medicaid crossover payments nationally so all Medicare beneficiaries in Louisiana and nationwide have equal access to their Medicare benefits.

- A copy of this Resolution will be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.[*]

Louisiana can lead the nation in healthcare justice for five million people.

> *Of all the forms of inequality, injustice in health care is the most shocking and inhumane.* — Martin Luther King, Jr.[1]

Louisiana can lead the nation in healthcare justice for 108,000 of the oldest, poorest, sickest, and most disabled people in our state, and five million people nationwide. These are dually eligible people. They are poor Medicare beneficiaries who also have Medicaid.

The Congressional Balanced Budget Act of 1997 allowed states to decrease their share of the Medicare payment for poor Medicare beneficiaries who also had Medicaid (Medicare-Medicaid crossover payments). This Act allowed poor Medicare beneficiaries to receive less physician reimbursement than wealthy beneficiaries and created a discriminatory, two-tiered Medicare system. See Figure 1.

In 2000, Louisiana joined two-thirds of all states and decreased payments for poor Medicare beneficiaries. In 2003, a Report to Congress by Tommy Thompson, Secretary of the U.S. Department of Health and Human Services, proved the Balanced Budget Act decreased their access to primary medical care by 5% and decreased their access to mental health services by 21%.[2]

Poor Medicare beneficiaries in Louisiana and nationwide are disproportionately elderly minorities and mentally and physically disabled people. These groups have long histories of suffering discrimination and are protected by the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Centers for Medicare & Medicaid Services (CMS) Civil Rights Compliance Policy.

Dually eligible beneficiaries are medically frail. They have more chronic illness than non-dually eligible Medicare beneficiaries, including more heart disease, diabetes, stroke,

[*] Full Resolution text is available at http://www.legis.state.la.us/billdata/streamdocument.asp?did=661366.

cancer, arthritis, pulmonary, liver and kidney disease, dementia, alcohol and substance abuse, schizophrenia, depression, mental retardation, and other illnesses.[3]

Dually eligible Medicare beneficiaries have a 50% higher mortality rate than non-dually eligible beneficiaries.[4] Senator John Breaux, Chairman of the Senate Special Committee on Aging, called them "the elderly and disabled poor."[5] More than one-quarter of all Medicare beneficiaries 85 years and older are dually eligible;[6] they fill two-thirds of all nursing home beds; 28% of all Medicare beneficiaries in Louisiana have Medicaid.[7]

All Medicare beneficiaries worked, paid payroll taxes, and earned the same Medicare benefits. A government policy that decreases reimbursement for Medicare beneficiaries solely because they are poor decreases access to health care and causes disproportionate harm to elderly minorities and mentally and physically disabled people in Louisiana and five million people nationwide.

We cannot reform health care and fix healthcare disparities without restoring full Medicare access for our oldest, poorest, sickest, and most disabled citizens. Restoring full Medicare payment for dually eligible people will save money by keeping elderly and disabled people in the community and out of expensive emergency rooms, hospitals, and nursing homes. It will improve access to primary medical care and mental health services, stop civil rights violations, and decrease government-induced healthcare disparities.[†]

This policy violates the intent of the Civil Rights Act of 1964.

Wealthy Medicare beneficiaries get *full* Medicare benefits, while poor beneficiaries get *partial* Medicare benefits. Because Medicare beneficiaries who are African American, Hispanic, and other minorities are disproportionately poorer than White beneficiaries, they suffer a disproportionate decrease in healthcare access. See Figure 1.

- The percentage of dually eligible people who are African American (21%) is more than *three times* the percentage of non-dually eligible Medicare beneficiaries who are African American (6.6%).

- The percentage of elderly dually eligible people who are Hispanic (13.7%) is *three times* the percentage of elderly non-dually eligible Medicare beneficiaries who are Hispanic (4.6%).[8]

Disproportionately decreasing Medicare access for African Americans, Hispanics, and other minorities solely because they are poor violates the intent of the disparate or disproportionate discrimination clause of the Civil Rights Act of 1964.

[†] For discussion and background, see "Healthcare Discrimination in New Orleans, Louisiana, and Nationwide: A Case Study of Dually Eligible People with Medicare and Medicaid," on our web site, http://www.nacdep.org. See also the video presentation to the New Orleans City Council on December 18, 2008, on our web site.

This policy violates the intent of the Americans with Disabilities Act.

Healthy and wealthy Medicare beneficiaries get *full* Medicare benefits, while poor beneficiaries with severe mental and physical disabilities get *partial* Medicare benefits and decreased healthcare access. Because Medicare beneficiaries with severe mental and physical disabilities are disproportionately poorer than healthy beneficiaries, they suffer a disproportionate decrease in healthcare access.

- The percentage of elderly dually eligible people with severe disabilities (27.2%) is almost *five times* the percentage of elderly non-dually eligible Medicare beneficiaries with severe disabilities (5.6%).

- The percentage of dually eligible people with mental illness (33%) is more than *twice* the percentage of non-dually eligible Medicare beneficiaries with mental illness (15%).

- Nursing home residents have the most severe disabilities, and two-thirds of all nursing home residents are dually eligible people. Dually eligible people are *eight* times more likely to live in a nursing home than non-dually eligible Medicare beneficiaries.[9]

Providing the *least* Medicare access for the *most* disabled people violates the intent of the Americans with Disabilities Act.

This program violates the intent of the CMS Civil Rights Compliance Policy.

Medicare was born as a civil rights bill in 1965, part of President Lyndon Johnson's Great Society. Following centuries of medical segregation, Medicare promised a single, nationwide system of health care that guaranteed equal access for all beneficiaries. In the CMS Civil Rights Compliance Policy Statement, Nancy-Ann DeParle[‡] pledged to abolish discrimination in all CMS programs. Ms. DeParle declared CMS

> guarantees that all our beneficiaries have equal access to the best health care. [CMS will integrate] compliance with civil rights laws into the fabric of all [CMS] program operations. . . . These laws include: Title VI of the Civil Rights Act . . . [and] the Americans with Disabilities Act . . . . [CMS will] allocate financial resources to . . . ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.[10]

[‡] From 1997 to 2000, Nancy-Ann DeParle was Administrator of the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services). Currently, she is Counselor to the President and Director of the White House Office of Health Reform.

Dually eligible people are the most costly population covered by any public healthcare program.

As access to primary care physicians decreases, expensive emergency room visits, hospitalizations, and nursing home admissions increase.[11] See Figure 2. Dually eligible people are the most expensive and fastest growing Medicare population; they are a fundamental part of the healthcare debate.

- Dually eligible people have a *preventable* hospitalization rate that is 40% higher than non-dually eligible people.[12]

- In 2005, dually eligible people cost Medicare and Medicaid almost $200 billion. State Medicaid agencies paid 60% of their total expense.

- The 7 million dually eligible Medicare beneficiaries cost *more* government money than 30 million non-dually eligible Medicare beneficiaries. The per capita cost for dually eligible Medicare beneficiaries is $20,902, compared with $4,553 for non-dually eligible beneficiaries.[13]

- In 2005, dually eligible people were only 18% of the national *Medicaid* population, but they consumed 46% of all Medicaid expenses.[14] In 2006 they were 16% of the national *Medicare* population, but they consumed 25% of all Medicare expenses.[15]

- In 2005, state Medicaid agencies paid 86% of long-term care services for dually eligible people.[16] Long-term care costs 58% of all Medicaid money spent on dually eligible people.[17]

Providing the *least* Medicare access for the *most* expensive Medicare population is financially irresponsible.

Restoring Medicare-Medicaid crossover payments has broad support.

Restoring Medicare-Medicaid crossover payments so all Medicare beneficiaries have equal access to their Medicare benefits is supported by the:

State of Louisiana
American Medical Association
American Geriatrics Society
Louisiana State Medical Society
Louisiana Geriatrics Society
Louisiana Medical Association
Louisiana Psychiatric Medical Association
Louisiana Medical Directors Association
Louisiana Dept. of Health and Hospitals
Orleans Parish Medical Society
Jefferson Parish Medical Society
St. Bernard Parish Medical Society
New Orleans Medical Association
New Orleans City Council
New Orleans Council on Aging
New Orleans Health Department
New Orleans NAACP

The Balanced Budget Act of 1997 created this problem.

Beginning in 1992, four federal appellate courts ruled that state Medicaid agencies had to pay crossover claims (the Medicare yearly deductible and 20% coinsurance) to ensure equal Medicare access for dually eligible people. In 1992, a federal court said if medical providers in New York were not reimbursed properly, "providers will . . . refrain from treating the most vulnerable of the elderly and disabled, those who are also poor [dually eligible people]." The court stated, "Such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act."[18]

In 1997, Congress passed the Balanced Budget Act and changed Medicare law. To save money for state Medicaid agencies, the Balanced Budget Act allowed states to stop paying the insurance bill for low-income Medicare beneficiaries that "crossed-over" to Medicaid. This change allowed poor Medicare beneficiaries to receive less physician reimbursement than wealthy Medicare beneficiaries, and created a two-tiered Medicare system. By 1999, two-thirds of states had reduced crossover payments.[19]

The Balanced Budget Act made it essentially *illegal* for five million dually eligible people — two-thirds of the national 7.5 million dually eligible population — to receive their full Medicare benefit. If a physician sees a patient with Medicare and Medicaid, once the physician accepts the patient's Medicare insurance, he or she *must* accept the combined Medicare and Medicaid fee as full payment; once Medicaid pays its reduced payment, it is illegal for the physician to accept further reimbursement from anyone else. The authors of Secretary Tommy Thompson's CMS-funded study concluded,

> [D]ually eligible Medicare beneficiaries may be a less attractive patient population for providers in many states. . . . Given a choice between a Medicare beneficiary for whom the physician expects to receive 100% of the fee schedule amount, and one for whom the physician expects to receive only 80%, theory predicts that the physician will prefer the first beneficiary. . . . Absent some type of policy change, however, access to Medicare services for dually eligible beneficiaries may continue to decline.[20]

A result of the Balanced Budget Act is that 108,000 dually eligible Medicare beneficiaries in Louisiana, and five million people across the nation, are now *legally segregated* into a discriminatory, second-class Medicare system. See Figure 1.

The Balanced Budget Act has a disproportionate impact along racial lines.

Access to healthcare is local and varies from neighborhood to neighborhood. The Balanced Budget Act has a disproportionate impact that depends upon a neighborhood's racial and economic makeup. It has little impact on wealthy neighborhoods where few low-income Medicare beneficiaries live, but it can devastate access to health care in poor neighborhoods and cities.

In 1999, Connecticut reduced crossover payments for its dually eligible Medicare beneficiaries, just as Louisiana did in 2000. Reducing crossover payments had little effect on healthcare access across the wealthy State of Connecticut, which has an 82% White majority. By contrast, this reduction devastated healthcare access in the poor City of Hartford, which is 72% African American, Hispanic, and other minorities.

According to a survey by the Fairfield County Medical Association, as a result of Connecticut's reduced crossover payments, 42% of their physicians limited or stopped accepting new dually eligible patients, 16% stopped seeing Medicaid patients in nursing homes, and 14% quit the Medicaid program.[21] Because of Hartford's demographics, most of that city's dually eligible people affected by Connecticut's crossover cuts were elderly minorities and mentally and physically disabled people.

Decreasing crossover payments has little effect on healthcare access in wealthy areas of Louisiana, but it has significant effect on healthcare access in poor sections of New Orleans. The percentage of elderly African Americans with decreased healthcare access in my Mid-City New Orleans medical practice (96%) is greater than *twice* the percentage of elderly African Americans in the New Orleans population (42%). See Figure 3.

Throughout Louisiana and the Southeastern United States, dually eligible people are disproportionately elderly African-American grandmothers, and mentally and physically disabled people. I enclose a petition requesting equal access to their Medicare benefit, signed by 40 dually eligible patients in my New Orleans practice. Of these 40 patients, 39 are African American, and 33 are women. One woman is 99 years old. Another woman is 103 years old.

Decreasing access to mental health services by 21%, as described in Secretary Thompson's report, heightens Louisiana's mental health crisis following Hurricane Katrina. Decreasing crossover payments causes a doctor drain out of poor neighborhoods and out of Louisiana. A physician working in a poor neighborhood in Louisiana will experience a 12% to 18% penalty for every dually eligible Medicare beneficiary the physician treats. It makes good economic sense for this physician to move to a wealthier neighborhood or move to another state that allows full Medicare payment.

Dually eligible people live in the intersection where Medicare's elderly and disabled world meets Medicaid's world of poverty. Dual eligibility is a social-medical-economic problem. The medical costs for these people are high because the medical problems associated with age and disability are multiplied by the social problems of being poor. Decreasing access to health care threatens their lives and is morally unjust.

This policy harms geriatric medicine.

Geriatrics is a specialty in decline. Despite our rapidly aging population, from 1998 (one year after the Balanced Budget Act was passed) to 2004 the number of geriatricians fell by one-third.[22] Geriatric physicians and psychiatrists concentrate on our nations' most

vulnerable citizens — frail, elderly people with complex, chronic health problems, severe mental and physical disabilities, dementia, and patients needing long-term care.

Medicare reimbursement is the most influential force shaping geriatric care in the United States; geriatricians receive most of their compensation from Medicare. Since decreasing Medicare-Medicaid crossover payments specifically targets our oldest, poorest, and sickest citizens, it also targets geriatricians who care for this frail, elderly population. Physicians working in low-income neighborhoods or nursing homes, and physicians who treat elderly minorities are particularly affected by decreasing crossover payments.

Medical students leaving medical school with the burden of student loans will not choose a career which labors under a "geriatric penalty" compared to all other specialties. As a result, fewer physicians choose to treat these elderly and disabled patients. Geriatricians may rightly shun states, such as Louisiana, that have a geriatric penalty in favor of states that do not have this geriatric penalty. Without restoring Medicare-Medicaid crossover payments geriatric medicine will continue to decline.

Without crossover payments, the proposed 5% Medicare bonus payment will decrease healthcare access.

To encourage primary medical care, Senators Max Baucus and Charles Grassley "proposed a 5 percent bonus payment for office visits and other 'primary care services' provided to Medicare patients by family doctors and internists."[23] Without restoring Medicare-Medicaid crossover payments, this 5% bonus will *worsen* healthcare access for dually eligible people and heighten disparities between wealthy beneficiaries and poor beneficiaries.

The Balanced Budget Act allowed states to reimburse dually eligible people up to the Medicare fee, up to the state Medicaid fee, or any fee in between. In 2008, Louisiana Medicaid reimbursed dually eligible people up to the Medicaid fee schedule, which, in New Orleans, was 85% of the Medicare fee schedule.

For example, assume Medicare allows $1.00 for a medical service, and Louisiana Medicaid allows $0.85 for the same service. (Medicare pays 80% of $1.00, or $0.80, and Louisiana Medicaid [the crossover payment] pays a nickel.) In this instance low-income, dually eligible Medicare beneficiaries "are worth" $0.15 less than wealthy beneficiaries. Since access to health care varies with insurance reimbursement, dually eligible people have decreased access compared to wealthy beneficiaries. (Secretary Tommy Thompson's 2003 Report to Congress proved this.)

Now assume Medicare gives a 5% bonus on top of the $1.00, making the medical service worth $1.05. But Louisiana Medicaid still allows only $0.85 for the same service, resulting in a larger payment disparity of $0.20 between dually eligible patients and non-dually eligible patients. (Medicare would pay 80% of $1.05, or $0.84, and Louisiana Medicaid [the crossover payment] would pay a penny.) As a result, dually eligible patients become even *less* attractive to the physician, and their access to health care

decreases further. For dually eligible people, it is the *Medicaid crossover payment* that controls their healthcare access — not the Medicare payment schedule.

As state budgets tighten in this recession, Medicaid rates may drop. If Medicare *increases* its payment schedule each year, and Medicaid *decreases* its payment schedule, the gap between the Medicare payment and the Medicaid payment will widen. This further decreases healthcare access for dually eligible people.

Even if Medicaid rates stay at current levels, the payment disparity for dually eligible people may still increase because Medicare rates usually increase each year. In 2008, Louisiana Medicaid reimbursement for dually eligible people in New Orleans was 85% of the Medicare payment. In 2009, Louisiana Medicaid kept its rates stable, but Medicare raised its payment schedule, and effectively increased the disparity between the two payment schedules. As a result, in 2009, the total reimbursement for dually eligible people in New Orleans decreased from 85% to 82% of the Medicare payment, further decreasing healthcare access for elderly and disabled, low-income Medicare beneficiaries.

Restoring crossover payments will cost taxpayers little.

Dually eligible people drive national healthcare costs. In 2005, they cost Medicare and Medicaid almost $200 billion. That same year, the cost to state Medicaid agencies to pay crossover payments (the yearly Medicare deductible and 20% coinsurance) for dually eligible people was $7.6 billion.[24]

States are broke. Because of the recession, Louisiana and other states cut millions of dollars from state budgets; it is financially and politically impossible for states to fix this problem on their own. Congress created this two-tiered, discriminatory Medicare system when it passed the Balanced Budget Act. Only Congress can fix this problem.

Medicaid is a joint federal-state program, and the federal government pays about 57% of all Medicaid expenses.[25] Therefore, in 2005, the federal government paid about $4.3 billion of the $7.6 billion crossover payments, and state treasuries paid the remaining $3.3 billion. It would have cost the federal government an extra $3.3 billion to take over the states' crossover share. Although a large sum, $3.3 billion is only 1.7% of the $200 billion national expense for dually eligible people in 2005.

Secretary Thompson's report showed that decreasing crossover payments decreased access to primary care physicians from 5% to 21%. Dually eligible people with multiple illnesses, multiple medications, and low health literacy have difficulty navigating a complicated healthcare system without primary care physician help. As access to primary care physicians for inexpensive *early*-stage medical care decreases, expensive emergency room visits, hospitalizations, and nursing home admissions for *late*-stage medical care increase. See Figure 2.

Identifying these vulnerable people before they enter a hospital or nursing home and providing them with access to high-quality, primary medical and psychiatric care in the community can save millions of dollars for Louisiana and billions for our nation. Without restoring crossover payments for community-based primary care physicians this goal remains elusive.

The federal government recently implemented the Medicare Part D drug benefit. The federal government can now help all states and low-income Medicare beneficiaries by paying all crossover payments for dually eligible people. Establishing a "Federal Crossover Program to Restore Access for Dually Eligible People" would be a

- *financial* success. If restoring access to primary medical care and mental health services saves only 1.7% of their $200 billion national healthcare bill, the program would pay for itself.

- *social* success. This program would stop racial, social, and civil rights problems caused by decreasing healthcare access for dually eligible people.

- *political* success. Dually eligible people, their families, state Medicaid agencies, medical societies, and organizations dealing with elderly and disabled people would favor such a program.

A Call to Action

Healthcare disparities have many causes. It will take decades to decrease concentrated poverty, eliminate racial and residential segregation, redistribute primary care physicians, and improve health literacy. But it takes only the flip of a legislative switch to decrease healthcare disparities created by the congressional policy that allowed low-income Medicare beneficiaries to receive less reimbursement than wealthy beneficiaries. A decision by Congress decreased crossover payments in 1997; a decision by Congress can restore them in 2009.

Six years have passed since Secretary Thompson's report, yet this social injustice continues. The U.S. Congress has the responsibility to ensure that any person who contributes to the Medicare program receives fair and nondiscriminatory health care. Any government program that subtracts benefits based solely on a person's poverty will have a disproportionate impact on elderly minorities and mentally and physically disabled people in Louisiana and nationwide. All Medicare beneficiaries paid Medicare taxes and therefore are entitled to equal Medicare access. Restoring Medicare-Medicaid crossover payments will allow Louisiana to lead the nation in healthcare justice for 108,000 frail people in our state and five million people nationwide.

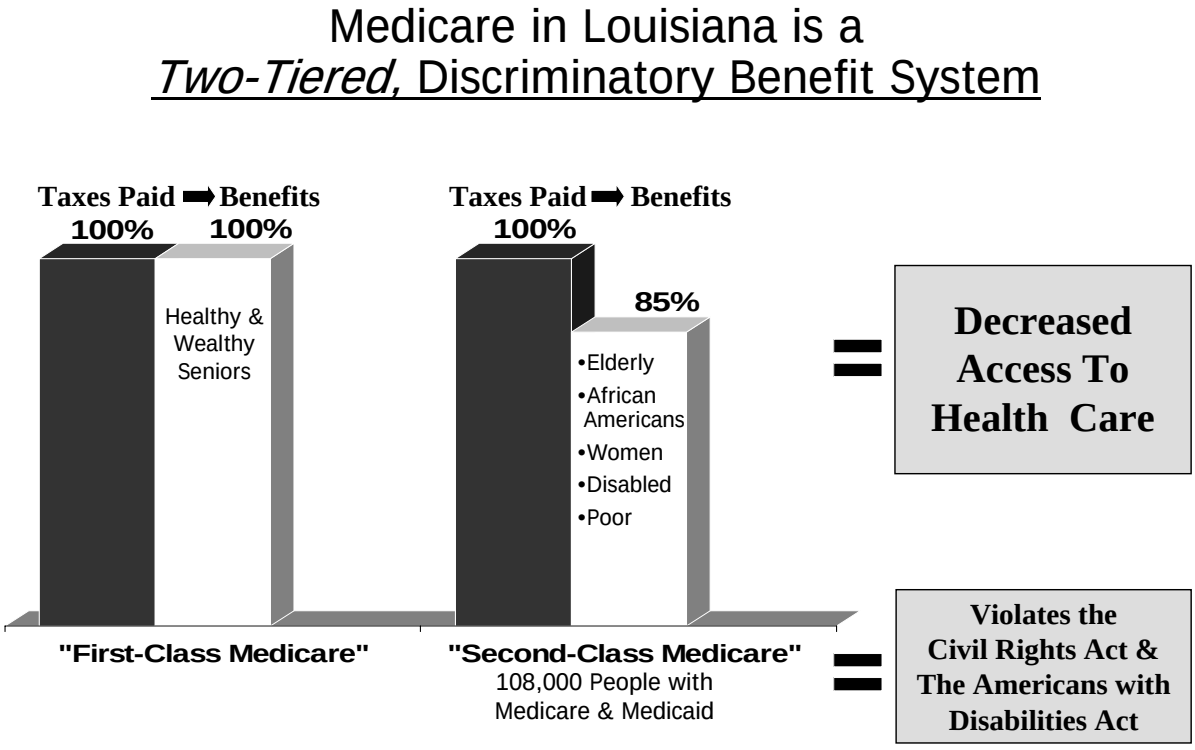

Figure 1. Without crossover payments, Medicare is a two-tiered, discriminatory benefit system. Healthy and wealthy Medicare beneficiaries paid 100% of their payroll taxes and receive 100% of their Medicare benefit. But poor Medicare beneficiaries who paid 100% of their payroll taxes receive only *partial* Medicare benefits; it is essentially *illegal* for these people to access their full Medicare benefit. These 108,000 poor Medicare beneficiaries in Louisiana and five million people across the nation are now legally segregated into a second-class Medicare system.

In 2008, dually eligible people in New Orleans received about 85% of their Medicare benefit. Secretary Thompson's Report to Congress proved this decreases their access to health care. This violates the intent of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the CMS Civil Rights Compliance Policy.

Good Healthcare Access Saves Money for Louisiana Medicaid

85-year-old Diabetic with Toe Infection (Medicare & Medicaid)

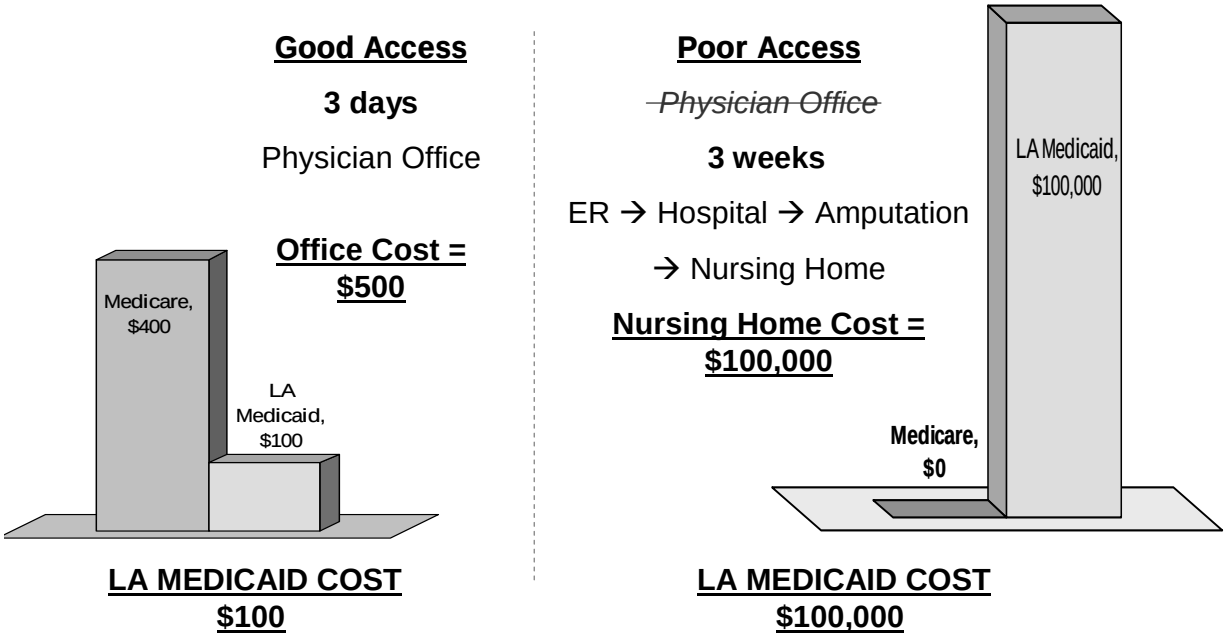

Figure 2. Good healthcare access saves money for Louisiana Medicaid. On the left-hand side, *with* the full Medicare crossover payment, this 85-year-old, dually eligible, diabetic patient with a toe infection can see her physician within three days. Because the illness is diagnosed early, the total cost for office visits and treatments is about $500. Medicare pays 80% or $400, and Louisiana Medicaid pays $100 (the crossover payment or 20% coinsurance which Medicare does not pay).

On the right-hand side, *without* the $100 crossover payment, the physician can no longer afford to see the patient. Three weeks later the patient's leg becomes infected. She goes to the emergency room by ambulance, is admitted to the hospital, and the gangrenous leg is amputated. She then spends the next 2 ½ years in a Louisiana nursing home at $40,000 a year. Because Medicare does not pay for custodial nursing home services the total cost to Louisiana Medicaid is $100,000.

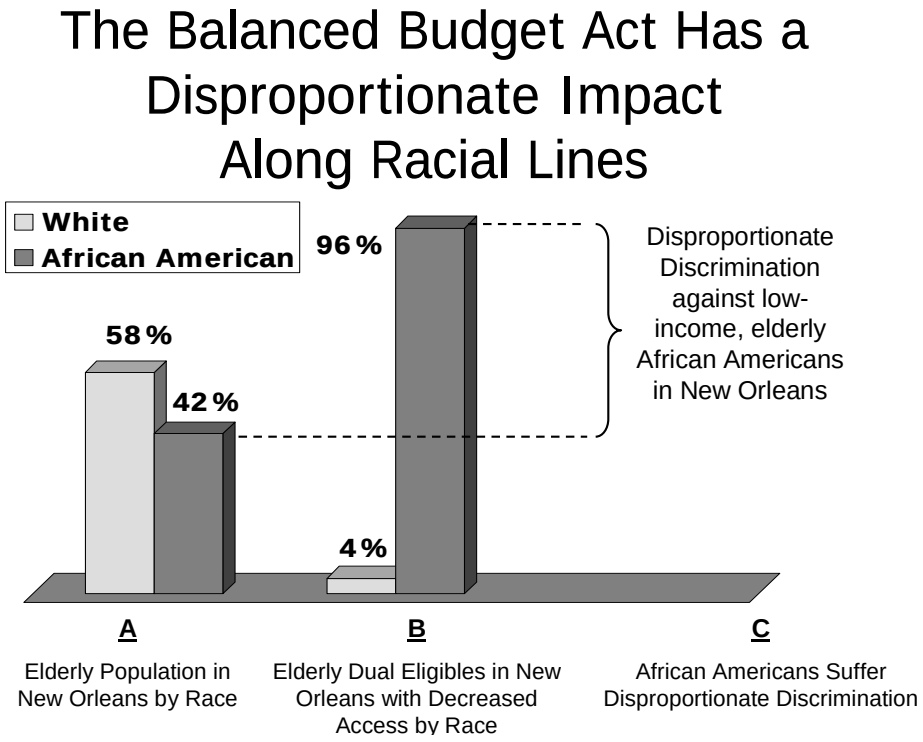

Figure 3. The Balanced Budget Act decreased healthcare access for poor Medicare beneficiaries. Because they are poorer than White Medicare beneficiaries, African-American beneficiaries in New Orleans suffer disproportionate discrimination.

Figure 3A. In 1997, of all elderly people in New Orleans 65 years old and older, African Americans were about 42% and White people were most of the rest.[26]

Figure 3B. African Americans are disproportionately poorer than Whites. Decreasing crossover payments and decreasing healthcare access affects only low-income Medicare beneficiaries who also have Medicaid. African Americans are poorer and therefore depend more on Medicaid than Whites. Although African Americans 65 years old and older were 42% of all elderly people in New Orleans, they were 96% of elderly dually eligible people in my medical practice in Mid-City New Orleans.

Figure 3C. Decreasing Medicare benefits based *solely* on low income has a disproportionate impact on African Americans. The percentage of elderly African Americans with decreased healthcare access (96%) is greater than *twice* the percentage of elderly African Americans in the New Orleans population (42%). According to the Civil Rights Act of 1964 this is disproportionate or disparate discrimination.

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